EXHIBIT 5

APPENDIX C
Additional Copies of Part II of the Questionnaire

PART II: ASBESTOS-RELATED CONDITION(S)

Name of Claimant: _____ **Last 4 Digits of SSN:** __ __ __ __

Mark the box next to the conditions with which you have been diagnosed and provide all information required in the instructions to this Questionnaire. If you have been diagnosed with multiple conditions and/or if you received diagnoses and diagnostic tests relating to the same condition by multiple doctors, please complete a separate Part II for each initial diagnosis and any previous or subsequent diagnoses or diagnostic tests that change or conflict with the initial diagnosis. For your convenience, additional copies of Part II are attached as Appendix C to this Questionnaire.

1. Please check the box next to the condition being alleged:

☐ Asbestos-Related Lung Cancer ☐ Mesothelioma
☐ Asbestosis ☐ Other Cancer (cancer not related to lung cancer or mesothelioma)
☐ Other Asbestos Disease ☐ Clinically Severe Asbestosis

a. Mesothelioma: If alleging Mesothelioma, were you diagnosed with malignant mesothelioma based on the following (check all that apply):

☐ diagnosis from a pathologist certified by the American Board of Pathology
☐ diagnosis from a second pathologist certified by the American Board of Pathology
☐ diagnosis and documentation supporting exposure to Grace asbestos-containing products having a substantial causal role in the development of the condition
☐ other (please specify):_____

b. Asbestos-Related Lung Cancer: If alleging Asbestos-Related Lung Cancer, were you diagnosed with primary lung cancer based on the following (check all that apply):

☐ findings by a pathologist certified by the American Board of Pathology
☐ evidence of asbestosis based on a chest x-ray reading of at least 1/1 on the ILO grade scale (a) conducted in compliance with the standards set forth in the International Labour Organization's *2000 International Classification of Radiographs of Pneumoconioses* and (b*)* by a B-reader certified by the National Institute for Occupational Safety and Health
☐ evidence of asbestosis based on a chest x-ray reading of at least 1/1 on the ILO grade scale (a) conducted in compliance with the standards set forth in the International Labour Organization's *2000 International Classification of Radiographs of Pneumoconioses* and (b*)* by a second B-reader certified by the National Institute for Occupational Safety and Health
☐ evidence of asbestosis determined by pathology
☐ evidence of asbestos-related nonmalignant disease based on a chest x-ray reading of at least 1/0 on the ILO grade scale (a) conducted in compliance with the standards set forth in the International Labour Organization's *2000 International Classification of Radiographs of Pneumoconioses* and (b*)* by a B-reader certified by the National Institute for Occupational Safety and Health
☐ evidence of asbestos-related nonmalignant disease based on a chest x-ray reading of at least 1/0 on the ILO grade scale (a) conducted in compliance with the standards set forth in the International Labour Organization's *2000 International Classification of Radiographs of Pneumoconioses* and (b*)* by a second B-reader certified by the National Institute for Occupational Safety and Health
☐ diffuse pleural thickening as defined in the International Labour Organization's *Guidelines for the Use of the ILO International Classification of Radiographs and Pneumoconioses* (2000)
☐ a supporting medical diagnosis and supporting documentation establishing that exposure to Grace asbestos-containing products had a substantial causal role in the development of the lung cancer
☐ other (please specify):_____

APPENDIX C
Additional Copies of Part II of the Questionnaire

PART II: ASBESTOS-RELATED CONDITION(S)

Name of Claimant: _____ **Last 4 Digits of SSN:** __ __ __ __

c. Other Cancer:

(i) If alleging Other Cancer, please mark the box(es) next to the applicable primary cancer(s) being alleged:

☐ colon ☐ pharyngeal ☐ esophageal ☐ laryngeal ☐ stomach cancer

☐ other, please specify: _____

(ii) Were you diagnosed with the above-indicated cancer based on the following (check all that apply):

☐ findings by a pathologist certified by the American Board of Pathology

☐ evidence of asbestosis based on a chest x-ray reading of at least 1/1 on the ILO grade scale (a) conducted in compliance with the standards set forth in the International Labour Organization's *2000 International Classification of Radiographs of Pneumoconioses* and (b*)* by a B-reader certified by the National Institute for Occupational Safety and Health

☐ evidence of asbestosis based on a chest x-ray reading of at least 1/1 on the ILO grade scale (a) conducted in compliance with the standards set forth in the International Labour Organization's *2000 International Classification of Radiographs of Pneumoconioses* and (b*)* by a second B-reader certified by the National Institute for Occupational Safety and Health

☐ evidence of asbestosis determined by pathology

☐ a supporting medical diagnosis and supporting documentation establishing that exposure to Grace asbestos-containing products had a substantial causal role in the development of the cancer

☐ other (please specify): _____

d. Clinically Severe Asbestosis: If alleging Clinically Severe Asbestosis, was your diagnosis based on the following (check all that apply):

☐ diagnosis of a pulmonologist or internist certified by the American Board of Internal Medicine

☐ a chest x-ray reading of at least 2/1 on the ILO grade scale (a) conducted in compliance with the standards set forth in the International Labour Organization's *2000 International Classification of Radiographs of Pneumoconioses* and (b*)* by a B-reader certified by the National Institute for Occupational Safety and Health

☐ a chest x-ray reading of at least 2/1 on the ILO grade scale (a) conducted in compliance with the standards set forth in the International Labour Organization's *2000 International Classification of Radiographs of Pneumoconioses* and (b*)* by a second B-reader certified by the National Institute for Occupational Safety and Health

☐ asbestosis determined by pathology

☐ a pulmonary function test, conducted in accordance with the standards set forth in the American Thoracic Society's *Lung Function Testing; Selection of Reference Values and Interpretive Strategies,* demonstrating total lung capacity less than 65% predicted

☐ a pulmonary function test, conducted in accordance with the standards set forth in the American Thoracic Society's *Lung Function Testing; Selection of Reference Values and Interpretive Strategies,* demonstrating forced vital capacity less than 65% predicted and a FEV1/FVC ratio greater than or equal to 65% predicted

☐ a supporting medical diagnosis and supporting documentation establishing that exposure to Grace asbestos-containing products had a substantial causal role in the development of the asbestosis

☐ other (please specify): _____

APPENDIX C

Additional Copies of Part II of the Questionnaire

PART II: ASBESTOS-RELATED CONDITION(S)

Name of Claimant: _____ **Last 4 Digits of SSN:** __ __ __ __

e. Asbestosis: If alleging Asbestosis, was your diagnosis based on the following (check all that apply):

- ☐ diagnosis of a pulmonologist or internist certified by the American Board of Internal Medicine
- ☐ a chest x-ray reading conducted in compliance with the standards set forth in the International Labour Organization's *2000 International Classification of Radiographs of Pneumoconioses* by a B-reader certified by the National Institute for Occupational Safety and Health, with one of the following: (i) at least 1/0 on the ILO grade scale, or (ii) diffuse pleural thickening as defined in the ILO's *Guidelines for the Use of the ILO International Classification of Radiographs and Pneumoconioses* (2000)
- ☐ a chest x-ray reading conducted in compliance with the standards set forth in the International Labour Organization's *2000 International Classification of Radiographs of Pneumoconioses* by a second B-reader certified by the National Institute for Occupational Safety and Health, with one of the following: (i) at least 1/0 on the ILO grade scale, or (ii) diffuse pleural thickening as defined in the ILO's *Guidelines for the Use of the ILO International Classification of Radiographs and Pneumoconioses* (2000)
- ☐ asbestosis determined by pathology
- ☐ a pulmonary function test, conducted in accordance with the standards set forth in the American Thoracic Society's *Lung Function Testing; Selection of Reference Values and Interpretive Strategies,* demonstrating a FEVI/FVC ratio greater than or equal to 65% predicted with either (a) total lung capacity less than 80% predicted or (b) forced vital capacity less than 80% predicted
- ☐ a supporting medical diagnosis and supporting documentation establishing that exposure to Grace asbestos-containing products had a substantial causal role in the development of the asbestosis
- ☐ other (please specify): _____

f. Other Asbestos Disease: If alleging any asbestos-related injuries, medical diagnoses, and/or conditions other than those above, was your diagnosis based on the following (check all that apply):

- ☐ diagnosis of a pulmonologist or internist certified by the American Board of Internal Medicine
- ☐ diagnosis determined by pathology
- ☐ a chest x-ray reading conducted in compliance with the standards set forth in the International Labour Organization's *2000 International Classification of Radiographs of Pneumoconioses* by a B-reader certified by the National Institute for Occupational Safety and Health, with one of the following: (i) at least 1/0 on the ILO grade scale, or (ii) diffuse pleural thickening as defined in the ILO's *Guidelines for the Use of the ILO International Classification of Radiographs and Pneumoconioses* (2000)
- ☐ a chest x-ray reading conducted in compliance with the standards set forth in the International Labour Organization's *2000 International Classification of Radiographs of Pneumoconioses* by a second B-reader certified by the National Institute for Occupational Safety and Health, with one of the following: (i) at least 1/0 on the ILO grade scale, or (ii) diffuse pleural thickening as defined in the ILO's *Guidelines for the Use of the ILO International Classification of Radiographs and Pneumoconioses* (2000)
- ☐ a chest x-ray reading other than those described above
- ☐ a pulmonary function test, conducted in accordance with the standards set forth in the American Thoracic Society's *Lung Function Testing; Selection of Reference Values and Interpretive Strategies,* demonstrating a FEVI/FVC ratio greater than or equal to 65% predicted with either (a) total lung capacity less than 80% predicted or (b) forced vital capacity less than 80% predicted
- ☐ a pulmonary function test other than that discussed above
- ☐ a supporting medical diagnosis and supporting documentation establishing that exposure to Grace asbestos-containing products had a substantial causal role in the development of the condition
- ☐ a CT Scan or similar testing
- ☐ a diagnosis other than those above
- ☐ other (please specify): _____

APPENDIX C

Additional Copies of Part II of the Questionnaire

PART II: ASBESTOS-RELATED CONDITION(S)

Name of Claimant: _____ **Last 4 Digits of SSN:** __ __ __ __

2. Information Regarding Diagnosis

Date of Diagnosis: ..... __ __ / __ __ / __ __ __ __

Diagnosing Doctor's Name: _____

Diagnosing Doctor's Specialty: _____

Diagnosing Doctor's Mailing Address: _____
Address

_____
City State/Province Zip/Postal Code

Diagnosing Doctor's Daytime Telephone Number: ..... (__ __ __) __ __ __ - __ __ __ __

With respect to your relationship to the diagnosing doctor, check all applicable boxes:

Was the diagnosing doctor your personal physician? ..... ☐ Yes ☐ No

Was the diagnosing doctor paid for the diagnostic services that he/she performed? ..... ☐ Yes ☐ No

If yes, please indicate who paid for the services performed: _____

Did you retain counsel in order to receive any of the services performed by the diagnosing doctor? ..... ☐ Yes ☐ No

Was the diagnosing doctor referred to you by counsel? ..... ☐ Yes ☐ No

Are you aware of any relationship between the diagnosing doctor and your legal counsel? ..... ☐ Yes ☐ No

If yes, please explain: _____

_____

Was the diagnosing doctor certified as a pulmonologist or internist by the American Board of Internal Medicine at the time of the diagnosis? ..... ☐ Yes ☐ No

Was the diagnosing doctor certified as a pathologist by the American Board of Pathology at the time of the diagnosis? ..... ☐ Yes ☐ No

Was the diagnosing doctor provided with your complete occupational, medical and smoking history prior to diagnosis? ..... ☐ Yes ☐ No

Did the diagnosing doctor perform a physical examination? ..... ☐ Yes ☐ No

Do you currently use tobacco products? ..... ☐ Yes ☐ No

Have you ever used tobacco products? ..... ☐ Yes ☐ No

If answer to either question is yes, please indicate whether you have regularly used any of the following tobacco products and the dates and frequency with which such products were used:

☐ **Cigarettes** **Packs Per Day (half pack = .5)** _____ **Start Year** __ __ __ __ **End Year** __ __ __ __

☐ **Cigars** **Cigars Per Day** _____ **Start Year** __ __ __ __ **End Year** __ __ __ __

☐ **If Other Tobacco Products, please specify (e.g., chewing tobacco):** _____
Amount Per Day _____ **Start Year** __ __ __ __ **End Year** __ __ __ __

Have you ever been diagnosed with chronic obstructive pulmonary disease ("COPD")? ..... ☐ Yes ☐ No

If yes, please attach all documents regarding such diagnosis and explain the nature of the diagnosis:

_____

3. Information Regarding Chest X-Ray

Please check the box next to the applicable location where your chest x-ray was taken (check one):

☐ Mobile laboratory ☐ Job site ☐ Union Hall ☐ Doctor office ☐ Hospital ☐ Other: _____

Address where chest x-ray taken: _____
Address

_____
City State/Province Zip/Postal Code

APPENDIX C

Additional Copies of Part II of the Questionnaire

PART II: ASBESTOS-RELATED CONDITION(S)

Name of Claimant: _____ **Last 4 Digits of SSN:** __ __ __ __

4. Information Regarding Chest X-Ray Reading

Date of Reading: __ __ / __ __ / __ __ __ __ **ILO score:** _____

Name of Reader: _____

Reader's Daytime Telephone Number: (__ __ __) __ __ __ - __ __ __ __

Reader's Mailing Address: _____
Address

_____
City State/Province Zip/Postal Code

With respect to your relationship to the reader, check all applicable boxes:

Was the reader paid for the services that he/she performed ☐ Yes ☐ No

If yes, please indicate who paid for the services performed: _____

Did you retain counsel in order to receive any of the services performed by the reader? ☐ Yes ☐ No

Was the reader referred to you by counsel? ☐ Yes ☐ No

Are you aware of any relationship between the reader and your legal counsel? ☐ Yes ☐ No

If yes, please explain: _____

Was the reader certified by the National Institute for Occupational Safety and Health at the time of the reading? ☐ Yes ☐ No

If the reader is not a certified B-reader, please describe the reader's occupation, specialty, and the method through which the reading was made: _____

5. Information Regarding Pulmonary Function Test: **Date of Test:** __ __ / __ __ / __ __ __ __

List your height in feet and inches when test given: _____ **ft** _____ **inches**

List your weight in pounds when test given: _____ **lbs**

Total Lung Capacity (TLC): _____**% of predicted**

Forced Vital Capacity (FVC): _____**% of predicted**

FEV1/FVC Ratio: _____**% of predicted**

Name of Doctor Performing Test (if applicable): _____

Doctor's Specialty: _____

Name of Clinician Performing Test (if applicable): _____

Testing Doctor or Clinician's Mailing Address: _____
Address

_____
City State/Province Zip/Postal Code

Testing Doctor or Clinician's Daytime Telephone Number: (__ __ __) __ __ __ - __ __ __ __

Name of Doctor Interpreting Test: _____

Doctor's Specialty: _____

Interpreting Doctor's Mailing Address: _____
Address

_____
City State/Province Zip/Postal Code..

Interpreting Doctor's Daytime Telephone Number: (__ __ __) __ __ __ - __ __ __ __

APPENDIX C
Additional Copies of Part II of the Questionnaire

PART II: ASBESTOS-RELATED CONDITION(S)

Name of Claimant: _____ **Last 4 Digits of SSN:** __ __ __ __

With respect to your relationship to the doctor or clinician who performed the pulmonary function test check all applicable boxes:

If the test was performed by a doctor, was the doctor your personal physician? ☐ Yes ☐ No

Was the testing doctor and/or clinician paid for the services that he/she performed? ☐ Yes ☐ No

If yes, please indicate who paid for the services performed: _____

Did you retain counsel in order to receive any of the services performed by the testing doctor or clinician? ☐ Yes ☐ No

Was the testing doctor or clinician referred to you by counsel? ☐ Yes ☐ No

Are you aware of any relationship between either the doctor or clinician and your legal counsel? ☐ Yes ☐ No

If yes, please explain: _____

Was the testing doctor certified as a pulmonologist or internist by the American Board of Internal Medicine at the time of the pulmonary function test? ☐ Yes ☐ No

With respect to your relationship to the doctor interpreting the results of the pulmonary function test check all applicable boxes:

Was the doctor your personal physician? ☐ Yes ☐ No

Was the doctor paid for the services that he/she performed? ☐ Yes ☐ No

If yes, please indicate who paid for the services performed: _____

Did you retain counsel in order to receive any of the services performed by the doctor? ☐ Yes ☐ No

Was the doctor referred to you by counsel? ☐ Yes ☐ No

Are you aware of any relationship between the doctor and your legal counsel? ☐ Yes ☐ No

If yes, please explain _____

Was the doctor interpreting the pulmonary function test results certified as a pulmonologist or internist by the American Board of Internal Medicine at the time the test results were reviewed? ☐ Yes ☐ No

6. Information Regarding Pathology Reports:

Date of Pathology Report: __ __ / __ __ / __ __ __ __

Findings: _____

Name of Doctor Issuing Report: _____

Doctor's Specialty: _____

Doctor's Mailing Address: _____
Address

_____
City State/Province Zip/Postal Code

Doctor's Daytime Telephone Number: (__ __ __) __ __ __ - __ __ __ __

With respect to your relationship to the doctor issuing the pathology report, check all applicable boxes:

Was the doctor your personal physician? ☐ Yes ☐ No

Was the doctor paid for the services that he/she performed? ☐ Yes ☐ No

If yes, please indicate who paid for the services performed: _____

Did you retain counsel in order to receive any of the services performed by the doctor? ☐ Yes ☐ No

Was the doctor referred to you by counsel? ☐ Yes ☐ No

Are you aware of any relationship between the doctor and your legal counsel? ☐ Yes ☐ No

If yes, please explain: _____

Was the doctor certified as a pathologist by the American Board of Pathology at the time of the diagnosis?

☐ Yes ☐ No

APPENDIX C
Additional Copies of Part II of the Questionnaire

PART II: ASBESTOS-RELATED CONDITION(S)

Name of Claimant: _____ **Last 4 Digits of SSN:** __ __ __ __

7. With respect to the condition alleged, have you received medical treatment from a doctor for the condition?

..... ☐ Yes ☐ No

If yes, please complete the following:

Name of Treating Doctor: _____

Treating Doctor's Specialty: _____

Treating Doctor's Mailing Address: _____
Address

_____
City State/Province Zip/Postal Code

Treating Doctor's Daytime Telephone number: ..... (__ __ __) __ __ __ - __ __ __ __

Was the doctor paid for the services that he/she performed? ..... ☐ Yes ☐ No

If yes, please indicate who paid for the services performed:. _____

Did you retain counsel in order to receive any of the services performed by the doctor? ..... ☐ Yes ☐ No

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APPENDIX C
Additional Copies of Part II of the Questionnaire

PART II: ASBESTOS-RELATED CONDITION(S)

Name of Claimant: _____ **Last 4 Digits of SSN:** __ __ __ __

Mark the box next to the conditions with which you have been diagnosed and provide all information required in the instructions to this Questionnaire. If you have been diagnosed with multiple conditions and/or if you received diagnoses and diagnostic tests relating to the same condition by multiple doctors, please complete a separate Part II for each initial diagnosis and any previous or subsequent diagnoses or diagnostic tests that change or conflict with the initial diagnosis. For your convenience, additional copies of Part II are attached as Appendix C to this Questionnaire.

1. Please check the box next to the condition being alleged:

☐ Asbestos-Related Lung Cancer
☐ Mesothelioma
☐ Asbestosis
☐ Other Cancer (cancer not related to lung cancer or mesothelioma)
☐ Other Asbestos Disease
☐ Clinically Severe Asbestosis

a. Mesothelioma: If alleging Mesothelioma, were you diagnosed with malignant mesothelioma based on the following (check all that apply):

☐ diagnosis from a pathologist certified by the American Board of Pathology
☐ diagnosis from a second pathologist certified by the American Board of Pathology
☐ diagnosis and documentation supporting exposure to Grace asbestos-containing products having a substantial causal role in the development of the condition
☐ other (please specify):_____

b. Asbestos-Related Lung Cancer: If alleging Asbestos-Related Lung Cancer, were you diagnosed with primary lung cancer based on the following (check all that apply):

☐ findings by a pathologist certified by the American Board of Pathology
☐ evidence of asbestosis based on a chest x-ray reading of at least 1/1 on the ILO grade scale (a) conducted in compliance with the standards set forth in the International Labour Organization's *2000 International Classification of Radiographs of Pneumoconioses* and (b*)* by a B-reader certified by the National Institute for Occupational Safety and Health
☐ evidence of asbestosis based on a chest x-ray reading of at least 1/1 on the ILO grade scale (a) conducted in compliance with the standards set forth in the International Labour Organization's *2000 International Classification of Radiographs of Pneumoconioses* and (b*)* by a second B-reader certified by the National Institute for Occupational Safety and Health
☐ evidence of asbestosis determined by pathology
☐ evidence of asbestos-related nonmalignant disease based on a chest x-ray reading of at least 1/0 on the ILO grade scale (a) conducted in compliance with the standards set forth in the International Labour Organization's *2000 International Classification of Radiographs of Pneumoconioses* and (b*)* by a B-reader certified by the National Institute for Occupational Safety and Health
☐ evidence of asbestos-related nonmalignant disease based on a chest x-ray reading of at least 1/0 on the ILO grade scale (a) conducted in compliance with the standards set forth in the International Labour Organization's *2000 International Classification of Radiographs of Pneumoconioses* and (b*)* by a second B-reader certified by the National Institute for Occupational Safety and Health
☐ diffuse pleural thickening as defined in the International Labour Organization's *Guidelines for the Use of the ILO International Classification of Radiographs and Pneumoconioses* (2000)
☐ a supporting medical diagnosis and supporting documentation establishing that exposure to Grace asbestos-containing products had a substantial causal role in the development of the lung cancer
☐ other (please specify):_____

APPENDIX C
Additional Copies of Part II of the Questionnaire

PART II: ASBESTOS-RELATED CONDITION(S)

Name of Claimant: _____ **Last 4 Digits of SSN:** __ __ __ __

c. Other Cancer:

(i) If alleging Other Cancer, please mark the box(es) next to the applicable primary cancer(s) being alleged:

☐ colon ☐ pharyngeal ☐ esophageal ☐ laryngeal ☐ stomach cancer

☐ other, please specify: _____

(ii) Were you diagnosed with the above-indicated cancer based on the following (check all that apply):

☐ findings by a pathologist certified by the American Board of Pathology

☐ evidence of asbestosis based on a chest x-ray reading of at least 1/1 on the ILO grade scale (a) conducted in compliance with the standards set forth in the International Labour Organization's *2000 International Classification of Radiographs of Pneumoconioses* and (b*)* by a B-reader certified by the National Institute for Occupational Safety and Health

☐ evidence of asbestosis based on a chest x-ray reading of at least 1/1 on the ILO grade scale (a) conducted in compliance with the standards set forth in the International Labour Organization's *2000 International Classification of Radiographs of Pneumoconioses* and (b*)* by a second B-reader certified by the National Institute for Occupational Safety and Health

☐ evidence of asbestosis determined by pathology

☐ a supporting medical diagnosis and supporting documentation establishing that exposure to Grace asbestos-containing products had a substantial causal role in the development of the cancer

☐ other (please specify): _____

d. Clinically Severe Asbestosis: If alleging Clinically Severe Asbestosis, was your diagnosis based on the following (check all that apply):

☐ diagnosis of a pulmonologist or internist certified by the American Board of Internal Medicine

☐ a chest x-ray reading of at least 2/1 on the ILO grade scale (a) conducted in compliance with the standards set forth in the International Labour Organization's *2000 International Classification of Radiographs of Pneumoconioses* and (b*)* by a B-reader certified by the National Institute for Occupational Safety and Health

☐ a chest x-ray reading of at least 2/1 on the ILO grade scale (a) conducted in compliance with the standards set forth in the International Labour Organization's *2000 International Classification of Radiographs of Pneumoconioses* and (b*)* by a second B-reader certified by the National Institute for Occupational Safety and Health

☐ asbestosis determined by pathology

☐ a pulmonary function test, conducted in accordance with the standards set forth in the American Thoracic Society's *Lung Function Testing; Selection of Reference Values and Interpretive Strategies,* demonstrating total lung capacity less than 65% predicted

☐ a pulmonary function test, conducted in accordance with the standards set forth in the American Thoracic Society's *Lung Function Testing; Selection of Reference Values and Interpretive Strategies,* demonstrating forced vital capacity less than 65% predicted and a FEV1/FVC ratio greater than or equal to 65% predicted

☐ a supporting medical diagnosis and supporting documentation establishing that exposure to Grace asbestos-containing products had a substantial causal role in the development of the asbestosis

☐ other (please specify): _____

APPENDIX C

Additional Copies of Part II of the Questionnaire

PART II: ASBESTOS-RELATED CONDITION(S)

Name of Claimant: _____ **Last 4 Digits of SSN:** __ __ __ __

e. Asbestosis: If alleging Asbestosis, was your diagnosis based on the following (check all that apply):

- ☐ diagnosis of a pulmonologist or internist certified by the American Board of Internal Medicine
- ☐ a chest x-ray reading conducted in compliance with the standards set forth in the International Labour Organization's *2000 International Classification of Radiographs of Pneumoconioses* by a B-reader certified by the National Institute for Occupational Safety and Health, with one of the following: (i) at least 1/0 on the ILO grade scale, or (ii) diffuse pleural thickening as defined in the ILO's *Guidelines for the Use of the ILO International Classification of Radiographs and Pneumoconioses* (2000)
- ☐ a chest x-ray reading conducted in compliance with the standards set forth in the International Labour Organization's *2000 International Classification of Radiographs of Pneumoconioses* by a second B-reader certified by the National Institute for Occupational Safety and Health, with one of the following: (i) at least 1/0 on the ILO grade scale, or (ii) diffuse pleural thickening as defined in the ILO's *Guidelines for the Use of the ILO International Classification of Radiographs and Pneumoconioses* (2000)
- ☐ asbestosis determined by pathology
- ☐ a pulmonary function test, conducted in accordance with the standards set forth in the American Thoracic Society's *Lung Function Testing; Selection of Reference Values and Interpretive Strategies,* demonstrating a FEVI/FVC ratio greater than or equal to 65% predicted with either (a) total lung capacity less than 80% predicted or (b) forced vital capacity less than 80% predicted
- ☐ a supporting medical diagnosis and supporting documentation establishing that exposure to Grace asbestos-containing products had a substantial causal role in the development of the asbestosis
- ☐ other (please specify): _____

f. Other Asbestos Disease: If alleging any asbestos-related injuries, medical diagnoses, and/or conditions other than those above, was your diagnosis based on the following (check all that apply):

- ☐ diagnosis of a pulmonologist or internist certified by the American Board of Internal Medicine
- ☐ diagnosis determined by pathology
- ☐ a chest x-ray reading conducted in compliance with the standards set forth in the International Labour Organization's *2000 International Classification of Radiographs of Pneumoconioses* by a B-reader certified by the National Institute for Occupational Safety and Health, with one of the following: (i) at least 1/0 on the ILO grade scale, or (ii) diffuse pleural thickening as defined in the ILO's *Guidelines for the Use of the ILO International Classification of Radiographs and Pneumoconioses* (2000)
- ☐ a chest x-ray reading conducted in compliance with the standards set forth in the International Labour Organization's *2000 International Classification of Radiographs of Pneumoconioses* by a second B-reader certified by the National Institute for Occupational Safety and Health, with one of the following: (i) at least 1/0 on the ILO grade scale, or (ii) diffuse pleural thickening as defined in the ILO's *Guidelines for the Use of the ILO International Classification of Radiographs and Pneumoconioses* (2000)
- ☐ a chest x-ray reading other than those described above
- ☐ a pulmonary function test, conducted in accordance with the standards set forth in the American Thoracic Society's *Lung Function Testing; Selection of Reference Values and Interpretive Strategies,* demonstrating a FEVI/FVC ratio greater than or equal to 65% predicted with either (a) total lung capacity less than 80% predicted or (b) forced vital capacity less than 80% predicted
- ☐ a pulmonary function test other than that discussed above
- ☐ a supporting medical diagnosis and supporting documentation establishing that exposure to Grace asbestos-containing products had a substantial causal role in the development of the condition
- ☐ a CT Scan or similar testing
- ☐ a diagnosis other than those above
- ☐ other (please specify): _____

APPENDIX C

Additional Copies of Part II of the Questionnaire

PART II: ASBESTOS-RELATED CONDITION(S)

Name of Claimant: _____ **Last 4 Digits of SSN:** __ __ __ __

2. Information Regarding Diagnosis

Date of Diagnosis: ..... __ __ / __ __ / __ __ __ __

Diagnosing Doctor's Name: _____

Diagnosing Doctor's Specialty: _____

Diagnosing Doctor's Mailing Address: _____
Address

_____
City State/Province Zip/Postal Code

Diagnosing Doctor's Daytime Telephone Number: ..... (__ __ __) __ __ __ - __ __ __ __

With respect to your relationship to the diagnosing doctor, check all applicable boxes:

Was the diagnosing doctor your personal physician? ..... ☐ Yes ☐ No

Was the diagnosing doctor paid for the diagnostic services that he/she performed? ..... ☐ Yes ☐ No

If yes, please indicate who paid for the services performed: _____

Did you retain counsel in order to receive any of the services performed by the diagnosing doctor? ..... ☐ Yes ☐ No

Was the diagnosing doctor referred to you by counsel? ..... ☐ Yes ☐ No

Are you aware of any relationship between the diagnosing doctor and your legal counsel? ..... ☐ Yes ☐ No

If yes, please explain: _____

_____

Was the diagnosing doctor certified as a pulmonologist or internist by the American Board of Internal Medicine at the time of the diagnosis? ..... ☐ Yes ☐ No

Was the diagnosing doctor certified as a pathologist by the American Board of Pathology at the time of the diagnosis? ..... ☐ Yes ☐ No

Was the diagnosing doctor provided with your complete occupational, medical and smoking history prior to diagnosis? ..... ☐ Yes ☐ No

Did the diagnosing doctor perform a physical examination? ..... ☐ Yes ☐ No

Do you currently use tobacco products? ..... ☐ Yes ☐ No

Have you ever used tobacco products? ..... ☐ Yes ☐ No

If answer to either question is yes, please indicate whether you have regularly used any of the following tobacco products and the dates and frequency with which such products were used:

☐ **Cigarettes** **Packs Per Day (half pack = .5)** _____ **Start Year** __ __ __ __ **End Year** __ __ __ __

☐ **Cigars** **Cigars Per Day** _____ **Start Year** __ __ __ __ **End Year** __ __ __ __

☐ **If Other Tobacco Products, please specify (e.g., chewing tobacco):** _____
Amount Per Day _____ **Start Year** __ __ __ __ **End Year** __ __ __ __

Have you ever been diagnosed with chronic obstructive pulmonary disease ("COPD")? ..... ☐ Yes ☐ No

If yes, please attach all documents regarding such diagnosis and explain the nature of the diagnosis:

_____

3. Information Regarding Chest X-Ray

Please check the box next to the applicable location where your chest x-ray was taken (check one):

☐ Mobile laboratory ☐ Job site ☐ Union Hall ☐ Doctor office ☐ Hospital ☐ Other: _____

Address where chest x-ray taken: _____
Address

_____
City State/Province Zip/Postal Code

APPENDIX C

Additional Copies of Part II of the Questionnaire

PART II: ASBESTOS-RELATED CONDITION(S)

Name of Claimant: _____ **Last 4 Digits of SSN:** __ __ __ __

4. Information Regarding Chest X-Ray Reading

Date of Reading: __ __ / __ __ / __ __ __ __ **ILO score:** _____

Name of Reader: _____

Reader's Daytime Telephone Number: (__ __ __) __ __ __ - __ __ __ __

Reader's Mailing Address: _____
Address

_____
City State/Province Zip/Postal Code

With respect to your relationship to the reader, check all applicable boxes:

Was the reader paid for the services that he/she performed ☐ Yes ☐ No

If yes, please indicate who paid for the services performed: _____

Did you retain counsel in order to receive any of the services performed by the reader? ☐ Yes ☐ No

Was the reader referred to you by counsel? ☐ Yes ☐ No

Are you aware of any relationship between the reader and your legal counsel? ☐ Yes ☐ No

If yes, please explain: _____

Was the reader certified by the National Institute for Occupational Safety and Health at the time of the reading? ☐ Yes ☐ No

If the reader is not a certified B-reader, please describe the reader's occupation, specialty, and the method through which the reading was made: _____

5. Information Regarding Pulmonary Function Test: **Date of Test:** __ __ / __ __ / __ __ __ __

List your height in feet and inches when test given: _____ **ft** _____ **inches**

List your weight in pounds when test given: _____ **lbs**

Total Lung Capacity (TLC): _____ **% of predicted**

Forced Vital Capacity (FVC): _____ **% of predicted**

FEV1/FVC Ratio: _____ **% of predicted**

Name of Doctor Performing Test (if applicable): _____

Doctor's Specialty: _____

Name of Clinician Performing Test (if applicable): _____

Testing Doctor or Clinician's Mailing Address: _____
Address

_____
City State/Province Zip/Postal Code

Testing Doctor or Clinician's Daytime Telephone Number: (__ __ __) __ __ __ - __ __ __ __

Name of Doctor Interpreting Test: _____

Doctor's Specialty: _____

Interpreting Doctor's Mailing Address: _____
Address

_____
City State/Province Zip/Postal Code..

Interpreting Doctor's Daytime Telephone Number: (__ __ __) __ __ __ - __ __ __ __

APPENDIX C
Additional Copies of Part II of the Questionnaire

PART II: ASBESTOS-RELATED CONDITION(S)

Name of Claimant: _____ **Last 4 Digits of SSN:** __ __ __ __

With respect to your relationship to the doctor or clinician who performed the pulmonary function test check all applicable boxes:

If the test was performed by a doctor, was the doctor your personal physician? ☐ Yes ☐ No

Was the testing doctor and/or clinician paid for the services that he/she performed? ☐ Yes ☐ No

If yes, please indicate who paid for the services performed: _____

Did you retain counsel in order to receive any of the services performed by the testing doctor or clinician? ☐ Yes ☐ No

Was the testing doctor or clinician referred to you by counsel? ☐ Yes ☐ No

Are you aware of any relationship between either the doctor or clinician and your legal counsel? ☐ Yes ☐ No

If yes, please explain: _____

Was the testing doctor certified as a pulmonologist or internist by the American Board of Internal Medicine at the time of the pulmonary function test? ☐ Yes ☐ No

With respect to your relationship to the doctor interpreting the results of the pulmonary function test check all applicable boxes:

Was the doctor your personal physician? ☐ Yes ☐ No

Was the doctor paid for the services that he/she performed? ☐ Yes ☐ No

If yes, please indicate who paid for the services performed: _____

Did you retain counsel in order to receive any of the services performed by the doctor? ☐ Yes ☐ No

Was the doctor referred to you by counsel? ☐ Yes ☐ No

Are you aware of any relationship between the doctor and your legal counsel? ☐ Yes ☐ No

If yes, please explain _____

Was the doctor interpreting the pulmonary function test results certified as a pulmonologist or internist by the American Board of Internal Medicine at the time the test results were reviewed? ☐ Yes ☐ No

6. Information Regarding Pathology Reports:

Date of Pathology Report: __ __ / __ __ / __ __ __ __

Findings: _____

Name of Doctor Issuing Report: _____

Doctor's Specialty: _____

Doctor's Mailing Address: _____
Address

_____
City State/Province Zip/Postal Code

Doctor's Daytime Telephone Number: (__ __ __) __ __ __ - __ __ __ __

With respect to your relationship to the doctor issuing the pathology report, check all applicable boxes:

Was the doctor your personal physician? ☐ Yes ☐ No

Was the doctor paid for the services that he/she performed? ☐ Yes ☐ No

If yes, please indicate who paid for the services performed: _____

Did you retain counsel in order to receive any of the services performed by the doctor? ☐ Yes ☐ No

Was the doctor referred to you by counsel? ☐ Yes ☐ No

Are you aware of any relationship between the doctor and your legal counsel? ☐ Yes ☐ No

If yes, please explain: _____

Was the doctor certified as a pathologist by the American Board of Pathology at the time of the diagnosis?

☐ Yes ☐ No

APPENDIX C
Additional Copies of Part II of the Questionnaire

PART II: ASBESTOS-RELATED CONDITION(S)

Name of Claimant: _____ **Last 4 Digits of SSN:** __ __ __ __

7. With respect to the condition alleged, have you received medical treatment from a doctor for the condition?

..... ☐ Yes ☐ No

If yes, please complete the following:

Name of Treating Doctor: _____

Treating Doctor's Specialty: _____

Treating Doctor's Mailing Address: _____
Address

_____
City State/Province Zip/Postal Code

Treating Doctor's Daytime Telephone number: ..... (__ __ __) __ __ __ - __ __ __ __

Was the doctor paid for the services that he/she performed? ..... ☐ Yes ☐ No

If yes, please indicate who paid for the services performed:. _____

Did you retain counsel in order to receive any of the services performed by the doctor? ..... ☐ Yes ☐ No

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APPENDIX D

Additional Copies of Part III of the Questionnaire **Name of Claimant:** _____ **Last 4 Digits of SSN:** __ __ __ __

PART III: DIRECT EXPOSURE TO GRACE ASBESTOS-CONTAINING PRODUCTS

Please complete the chart below for each site at which you allege exposure to Grace asbestos-containing products. If you allege exposure at multiple sites, the Court has ordered that you must complete a separate chart for each site. For your convenience, additional copies of Part III are attached as Appendix D to this Questionnaire.

If exposure was in connection with your employment, use the list of occupation and industry codes in the Instructions to Part III to indicate your occupation and the industry in which you worked.

In the "Nature of Exposure" column, for each job listed, please indicate the letter(s) corresponding to whether you were any of the following during your exposure:

(a) A worker who personally mixed Grace asbestos-containing products

(b) A worker who personally removed or cut Grace asbestos-containing products

(c) A worker who personally installed Grace asbestos-containing products

(d) A worker at a site where Grace asbestos-containing products were being installed, mixed, removed or cut by others

(e) A worker in a space where Grace asbestos-containing products were being installed, mixed, removed or cut by others

(f) If other, please specify.

Site of Exposure:

Site Name:_____ Location:_____

Site Type: ☐ Residence ☐ Business Site Owner:_____

Employer During Exposure:_____ Unions of which you were a member during your employment: _____

	Product(s)	**Basis for Identification of Each Grace Product**	**Dates and Frequency of Exposure (hours/day, days/year)**	**Occupation Code** *If Code 59, specify.*	**Industry Code** *If Code 118, specify.*	**Was exposure due to working in or around areas where product was being installed, mixed, removed, or cut?** *If Yes, please indicate your regular proximity to such areas*	**Nature of Exposure**
Job 1 Description:							
Job 2 Description:							
Job 3 Description:							
Job 4 Description:							
Job 5 Description:							
Job 6 Description:							

APPENDIX D

Additional Copies of Part III of the Questionnaire **Name of Claimant:** _____ **Last 4 Digits of SSN:** __ __ __ __

PART III: DIRECT EXPOSURE TO GRACE ASBESTOS-CONTAINING PRODUCTS

Please complete the chart below for each site at which you allege exposure to Grace asbestos-containing products. If you allege exposure at multiple sites, the Court has ordered that you must complete a separate chart for each site. For your convenience, additional copies of Part III are attached as Appendix D to this Questionnaire.

If exposure was in connection with your employment, use the list of occupation and industry codes in the Instructions to Part III to indicate your occupation and the industry in which you worked.

In the "Nature of Exposure" column, for each job listed, please indicate the letter(s) corresponding to whether you were any of the following during your exposure:

(d) A worker who personally mixed Grace asbestos-containing products

(e) A worker who personally removed or cut Grace asbestos-containing products

(f) A worker who personally installed Grace asbestos-containing products

(g) A worker at a site where Grace asbestos-containing products were being installed, mixed, removed or cut by others

(h) A worker in a space where Grace asbestos-containing products were being installed, mixed, removed or cut by others

(i) If other, please specify.

Site of Exposure:

Site Name:_____ Location:_____

Site Type: ☐ Residence ☐ Business Site Owner:_____

Employer During Exposure:_____ Unions of which you were a member during your employment: _____

	Product(s)	**Basis for Identification of Each Grace Product**	**Dates and Frequency of Exposure (hours/day, days/year)**	**Occupation Code** *If Code 59, specify.*	**Industry Code** *If Code 118, specify.*	**Was exposure due to working in or around areas where product was being installed, mixed, removed, or cut?** *If Yes, please indicate your regular proximity to such areas*	**Nature of Exposure**
Job 1 Description:							
Job 2 Description:							
Job 3 Description:							
Job 4 Description:							
Job 5 Description:							
Job 6 Description:							

APPENDIX E
Additional Copies of Part IV of the Questionnaire

PART IV: INDIRECT EXPOSURE TO GRACE ASBESTOS-CONTAINING PRODUCTS

Name of Claimant: _____ **Last 4 Digits of SSN:** __ __ __ __

1. **Are you asserting an injury caused by exposure to Grace asbestos-containing products through contact/proximity with another injured person?** ☐ Yes ☐ No

   If yes, complete questions 2 through 10 of this section for each injured person through which you allege exposure to Grace asbestos-containing products. For your convenience, additional copies of Part IV are attached as Appendix E to this Questionnaire.

2. **Please indicate the following information regarding the other injured person:**

   Name of Other Injured Person: _____ **Gender:** ☐ Male ☐ Female

   Last Four Digits of Social Security Number: __ __ __ __ **Birth Date:** __ __ / __ __ / __ __

3. **What is your Relationship to Other Injured Person:** ☐ Spouse ☐ Child ☐ Other

4. **Nature of Other Injured Person's Exposure to Grace Asbestos-Containing Products:**

   _____

5. **Dates Other Injured Person was Exposed to Grace Asbestos-Containing Products:**
   From: __ __ / __ __ / __ __ __ __ **To:** __ __ / __ __ / __ __ __ __

6. **Other Injured Person's Basis for Identification of Asbestos-Containing Product as Grace Product:**

   _____

7. **Has the Other Injured Person filed a lawsuit related to his/her exposure?** ☐ Yes ☐ No

   If yes, please provide caption, case number, file date, and court name for the lawsuit:

   Caption: _____

   Case Number: _____ **File Date:** __ __ / __ __ / __ __ __ __

   Court Name: _____

8. **Nature of Your Own Exposure to Grace Asbestos-Containing Product:**

   _____

9. **Dates of Your Own Exposure to Grace Asbestos-Containing Product:**
   From: __ __ / __ __ / __ __ __ __ **To:** __ __ / __ __ / __ __ __ __

10. **Your Basis for Identification of Asbestos-Containing Product as Grace Product:**

    _____

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APPENDIX E
Additional Copies of Part IV of the Questionnaire

PART IV: INDIRECT EXPOSURE TO GRACE ASBESTOS-CONTAINING PRODUCTS

Name of Claimant: _____ **Last 4 Digits of SSN:** __ __ __ __

1. **Are you asserting an injury caused by exposure to Grace asbestos-containing products through contact/proximity with another injured person?** ☐ Yes ☐ No

   If yes, complete questions 2 through 10 of this section for each injured person through which you allege exposure to Grace asbestos-containing products. For your convenience, additional copies of Part IV are attached as Appendix E to this Questionnaire.

2. **Please indicate the following information regarding the other injured person:**

   Name of Other Injured Person: _____ **Gender:** ☐ Male ☐ Female

   Last Four Digits of Social Security Number: __ __ __ __ **Birth Date:** __ __ / __ __ / __ __

3. **What is your Relationship to Other Injured Person:** ☐ Spouse ☐ Child ☐ Other

4. **Nature of Other Injured Person's Exposure to Grace Asbestos-Containing Products:**

   _____

5. **Dates Other Injured Person was Exposed to Grace Asbestos-Containing Products:**
   From: __ __ / __ __ / __ __ __ __ **To:** __ __ / __ __ / __ __ __ __

6. **Other Injured Person's Basis for Identification of Asbestos-Containing Product as Grace Product:**

   _____

7. **Has the Other Injured Person filed a lawsuit related to his/her exposure?** ☐ Yes ☐ No

   If yes, please provide caption, case number, file date, and court name for the lawsuit:

   Caption: _____

   Case Number: _____ **File Date:** __ __ / __ __ / __ __ __ __

   Court Name: _____

8. **Nature of Your Own Exposure to Grace Asbestos-Containing Product:**

   _____

9. **Dates of Your Own Exposure to Grace Asbestos-Containing Product:**
   From: __ __ / __ __ / __ __ __ __ **To:** __ __ / __ __ / __ __ __ __

10. **Your Basis for Identification of Asbestos-Containing Product as Grace Product:**

    _____

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APPENDIX F

Additional Copies of Part V of the Questionnaire **Name of Claimant:** _____ **Last 4 Digits of SSN:** __ __ __ __

PART V: EXPOSURE TO NON-GRACE ASBESTOS-CONTAINING PRODUCTS

Please complete the chart below for each party against which you have filed a lawsuit and/or claim alleging exposure to asbestos-containing products other than Grace products. If you filed such lawsuits and/or claims against multiple parties, the Court has ordered that you must complete a separate chart for each party. For your convenience, additional copies of Part V are attached as Appendix F to this Questionnaire.

If exposure was in connection with your employment, use the list of occupation and industry codes in the Instructions to Part III to indicate your occupation and the industry in which you worked.

In the "Nature of Exposure" column, for each product listed, please indicate the letter(s) corresponding to whether you were any of the following during your exposure:

(a) A worker who personally mixed Non-Grace asbestos-containing products
(b) A worker who personally removed or cut Non-Grace asbestos-containing products
(c) A worker who personally installed Non-Grace asbestos-containing products
(d) A worker at a site where Non-Grace asbestos-containing products were being installed, mixed, removed or cut by others
(e) A worker in a space where Non-Grace asbestos-containing products were being installed, mixed, removed or cut by others
(f) If other, please specify.

Party Against which Lawsuit or Claim was Filed: _____		**Product(s)**	**Dates and Frequency of Exposure (hours/day, days/year)**	**Occupation Code** *If Code 59, specify.*	**Industry Code** *If Code 118, specify.*	**Was exposure due to working in or around areas where product was being installed, mixed, removed, or cut?** *If Yes, please indicate your regular proximity to such areas*	**Nature of Exposure**
Site of Exposure 1 Site Name:_____ Address:_____ City and State:_____ Site Owner:_____	Job 1 Description:						
	Job 2 Description:						
	Job 3 Description:						
Site of Exposure 2 Site Name:_____ Address:_____ City and State:_____ Site Owner:_____	Job 1 Description:						
	Job 2 Description:						
	Job 3 Description:						
Site of Exposure 3 Site Name:_____ Address:_____ City and State:_____ Site Owner:_____	Job 1 Description:						
	Job 2 Description:						
	Job 3 Description:						

APPENDIX F

Additional Copies of Part V of the Questionnaire **Name of Claimant:** _____ **Last 4 Digits of SSN:** __ __ __ __

PART V: EXPOSURE TO NON-GRACE ASBESTOS-CONTAINING PRODUCTS

Please complete the chart below for each party against which you have filed a lawsuit and/or claim alleging exposure to asbestos-containing products other than Grace products. If you filed such lawsuits and/or claims against multiple parties, the Court has ordered that you must complete a separate chart for each party. For your convenience, additional copies of Part V are attached as Appendix F to this Questionnaire.

If exposure was in connection with your employment, use the list of occupation and industry codes in the Instructions to Part III to indicate your occupation and the industry in which you worked.

In the "Nature of Exposure" column, for each product listed, please indicate the letter(s) corresponding to whether you were any of the following during your exposure:

(d) A worker who personally mixed Non-Grace asbestos-containing products
(e) A worker who personally removed or cut Non-Grace asbestos-containing products
(f) A worker who personally installed Non-Grace asbestos-containing products
(g) A worker at a site where Non-Grace asbestos-containing products were being installed, mixed, removed or cut by others
(h) A worker in a space where Non-Grace asbestos-containing products were being installed, mixed, removed or cut by others
(i) If other, please specify.

Party Against which Lawsuit or Claim was Filed: _____		**Product(s)**	**Dates and Frequency of Exposure (hours/day, days/year)**	**Occupation Code** *If Code 59, specify.*	**Industry Code** *If Code 118, specify.*	**Was exposure due to working in or around areas where product was being installed, mixed, removed, or cut?** *If Yes, please indicate your regular proximity to such areas*	**Nature of Exposure**
Site of Exposure 1 Site Name:_____ Address:_____ City and State:_____ Site Owner:_____	Job 1 Description:						
	Job 2 Description:						
	Job 3 Description:						
Site of Exposure 2 Site Name:_____ Address:_____ City and State:_____ Site Owner:_____	Job 1 Description:						
	Job 2 Description:						
	Job 3 Description:						
Site of Exposure 3 Site Name:_____ Address:_____ City and State:_____ Site Owner:_____	Job 1 Description:						
	Job 2 Description:						
	Job 3 Description:						

APPENDIX G
Additional Copies of Part VI of the Questionnaire

PART VI: EMPLOYMENT HISTORY

Name of Claimant: ______________________________ **Last 4 Digits of SSN:** __ __ __ __

Other than jobs listed in Part III or V, please complete this Part VI for all of your prior industrial work experience up to and including your current employment. For each job, include your employer, location of employment, and dates of employment. Only include jobs at which you worked for at least one month. Please use the copy of Part VI attached as Appendix G to this Questionnaire if additional space is needed.

Occupation Code: ________ If Code 59, specify: .______________________________

Industry Code: ________ If Code 118, specify:______________________________

Employer: ______________________________

Beginning of Employment: __ __ / __ __ / __ __ __ __ **End of Employment:** __ __ / __ __ / __ __ __ __

Location: ______________________________
Address

____
City State/Province Zip/Postal Code

Occupation Code: ________ If Code 59, specify: .______________________________

Industry Code: ________ If Code 118, specify:______________________________

Employer: ______________________________

Beginning of Employment: __ __ / __ __ / __ __ __ __ **End of Employment:** __ __ / __ __ / __ __ __ __

Location: ______________________________
Address

____
City State/Province Zip/Postal Code

Occupation Code: ________ If Code 59, specify: .______________________________

Industry Code: ________ If Code 118, specify:______________________________

Employer: ______________________________

Beginning of Employment: __ __ / __ __ / __ __ __ __ **End of Employment:** __ __ / __ __ / __ __ __ __

Location: ______________________________
Address

____
City State/Province Zip/Postal Code

Occupation Code: ________ If Code 59, specify: .______________________________

Industry Code: ________ If Code 118, specify:______________________________

Employer: ______________________________

Beginning of Employment: __ __ / __ __ / __ __ __ __ **End of Employment:** __ __ / __ __ / __ __ __ __

Location: ______________________________
Address

____
City State/Province Zip/Postal Code

APPENDIX G
Additional Copies of Part VI of the Questionnaire

PART VI: EMPLOYMENT HISTORY

Name of Claimant: ______________________________ **Last 4 Digits of SSN:** __ __ __ __

Other than jobs listed in Part III or V, please complete this Part VI for all of your prior industrial work experience up to and including your current employment. For each job, include your employer, location of employment, and dates of employment. Only include jobs at which you worked for at least one month. Please use the copy of Part VI attached as Appendix G to this Questionnaire if additional space is needed.

Occupation Code: __________ If Code 59, specify: .______________________________

Industry Code: __________ If Code 118, specify:______________________________

Employer: ______________________________

Beginning of Employment: __ __ / __ __ / __ __ __ __ **End of Employment:** __ __ / __ __ / __ __ __ __

Location: ______________________________
Address

____
City State/Province Zip/Postal Code

Occupation Code: __________ If Code 59, specify: .______________________________

Industry Code: __________ If Code 118, specify:______________________________

Employer: ______________________________

Beginning of Employment: __ __ / __ __ / __ __ __ __ **End of Employment:** __ __ / __ __ / __ __ __ __

Location: ______________________________
Address

____
City State/Province Zip/Postal Code

Occupation Code: __________ If Code 59, specify: .______________________________

Industry Code: __________ If Code 118, specify:______________________________

Employer: ______________________________

Beginning of Employment: __ __ / __ __ / __ __ __ __ **End of Employment:** __ __ / __ __ / __ __ __ __

Location: ______________________________
Address

____
City State/Province Zip/Postal Code

Occupation Code: __________ If Code 59, specify: .______________________________

Industry Code: __________ If Code 118, specify:______________________________

Employer: ______________________________

Beginning of Employment: __ __ / __ __ / __ __ __ __ **End of Employment:** __ __ / __ __ / __ __ __ __

Location: ______________________________
Address

____
City State/Province Zip/Postal Code